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I 000	INITIAL COMMENTS A licensure survey was conducted on September 20, 2010. A random sampling of two residents was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home, interviews with one residents/staff, and the review of clinical and administrative records, including incident/investigation reports.	I 000	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 11-5-10	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for four of four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: On September 20, 2010, beginning at approximately 11:00 a.m. an environmental inspection was conducted at the facility with the House Manager (HM) and the following was observed. Interior:	I 090		

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I 090	Continued From page 1 1. The inside carpeting leading to the living room had noticeable spots. The HM explained this was done accidentally by staff and they were in the process of replacing the carpet. 2. In the dinning room four of four chair cushions were soiled. 3. In the common bathroom there was chipping and peeling paint on the bathtub's surface, and the faucet of the tub was leaking. This deficiency of the chipping and peeling paint was cited in last years inspection. This was also acknowledged by the HM at approximately 11:20 a.m. 4. In the bathroom of Resident #1, the cabinet under the sink did not close properly. 5. In bedroom #4 which is located in the basement the staff had stored office files in the Resident #4's closet. Exterior 6. The rear storm door's handle on the first floor was broken and posed a cutting hazard to residents or staff. 7. The rear porch floor had loose boards and could pose a trip hazard to residents and staff. The HM acknowledged these findings on September 20, 2010 at approximately 11:30 a.m.	I 090	INTERIOR: 1. Replaced ~~carpte~~ carpet leading to living room. 11/19/10 2. Replaced four dining room chairs. 11/19/10 3. Common bathroom painted and tub refinished 11/19/10 4. Repaired cabinet door. 11/19/10 5. Removed office files from closet. 11/4/10 EXTERIOR: 6. Replaced rear storm door handle. 11/19/10 7. Repair loose boards on rear porch floor. 11/19/10 Additionally Facility Manager will complete a facility checklist weekly to ensure safety and appearance of facility.	
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.	I 202		

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I 202	Continued From page 2 This Statute is not met as evidenced by: Based on record review and staff interview, the group home for mentally retarded person's (GHMRP) failed to ensure all staff was provided a written job description for two (2) of eight (8) records reviewed as required by this section. (Staff #3 and #6) The finding includes: Record review and interview with the GHMRP's Qualified Mental Retardation Professional (QMRP) on September 20, 2010 at approximately 2:15 p.m., revealed two (2) of eight (8) staff (Staff #3 and #6) were without a written job description in their personnel files. The QMRP acknowledged the finding at approximately 2:30 p.m.	I 202	Job descriptions for staff #3 and #6 are signed, dated and available for review in record.	11/5/10
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all employees had current health certificates, for two (2) of eight (8) staff (Staff #5 and #6), and two (2) of ten (10)	I 206	Health certifications for Staff # 5 and #6 are filed in record and available for review.	

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I 206	Continued From page 3 consultants (Social Worker and Psychiatrist) did not have current certificates. The findings include: On September 20, 2010, beginning at approximately 1:30 p.m., review of the personnel records revealed the GHMRP failed to provide evidence that current health certificates were on file for Staff #5 ,#6 and the Social Worker and Psychiatrist. The qualified mental retardation professional (QMRP) acknowledged the findings at approximately 3:00 p.m.	I 206	Health Certificates for Staff #5 and #6 and the Social Worker and Psychiatrist are in the record and available for review.	11/5/10
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the training program agenda was maintained in the group home for persons with mental retardation (GHMRP) and available for review by regulatory agencies for one of two residents in the sample. (Resident #1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on September 20, 2010 at approximately 8:50 a.m. revealed Resident #1 was a new admission transferred to the facility on September 7, 2010. Continued interview revealed the resident was prescribed psychotropic medication and had a Behavior	I 223		

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I 223	Continued From page 4 Support Plan.. Review of the resident's medical record on September 20, 2010 beginning at approximately 2:34 p.m., revealed a physicians's order (PO) dated September 2010. According to the PO, Resident #1 was prescribed Paroxetine 20 mg for depression, and Risperidone 0.5 mg for agitation/aggression. Further review of the PO revealed Resident #1 also had an order to change (CPAP every 6 months). It should be noted Resident #1's diagnosis included, Asthma, Chronic Rhinitis, Hx of Xeros, Agitation& Aggressive Behaviors and Hypercholesterolemia. Interview with one of the facility's Licensed Practical Nurses (LPN) on September 20, 2010 at approximately 3:00 p.m., revealed the staff was trained by one of the facility's Registered Nurses (RN) on September 13, 2010. The LPN presented a sign-in sheet which revealed the presenter (RN) entitled the training "Health Care Plan Training." At the time of the survey, although there was evidence of staff participation on September 13, 2010, there was no documented evidence of the program agenda of the items covered regarding Resident #1's aforementioned medical history.	I 223	Please find attached HMCP that was used to train staff.	11/5/10
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by:	I 227		

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I 227	Continued From page 5 Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for two of the fifteen staff. (Staff #5 and #10) The finding includes: Review of the personnel and training records on September 8, 2010, beginning at 2:30 p.m., revealed the GHMRP failed to provide documentation of first aide, cardiopulmonary resulcitation (CPR, for one of eight staff (Staff #8). . The qualified mental retardation professional acknowledged these deficiencies during the exit conference on September 20, 2010, at approximately 3:10 p.m.	I 227	CPR and first aid certifications for staff #5 and #10 are in the staff's record and available for review.	10/5/10
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with mental retardation (GHMRP) failed to ensure all staff received training on the implementation of a resident's behavior support plan (BSP) for one of two residents included in the sample. (Resident #1)	I 229	Please find attached training documentation which indicates that all staff were trained on the individuals' BSP by 10/2/10. Additionally all staff receive ongoing training and specific BSP training annually or as needed.	11/5/10

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I 229	Continued From page 6 The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on September 20, 2010 at approximately 8:50 a.m. revealed Resident #1 was a new admission transferred to the facility on September 7, 2010. Continued interview revealed the resident was prescribed psychotropic medication and had a Behavior Support Plan (BSP). Observation on September 20, 2010 at approximately 5:13 p.m. revealed Resident #1 pacing back and forth in the facility's living room. Interview with the staff revealed that he was looking for something. Record review on September 20, 2010 at approximately 4:14 p.m. revealed Resident #1 had a Behavior Support Plan (BSP) dated April 14, 2010. According to the BSP, Resident #1's targeted behaviors included agitated behaviors in which he would exhibit loud vocalizations, pacing, mouthing/biting hand when frustrated or agitated about something. Additionally, the resident had a targeted behavior of pocketing items that do not belong to him. Further review of the BSP revealed the following: Agitation: "Functional analysis shows that this behavior occurs when he is unable to convey his needs or wants effectively to staff. Resident #1 dislikes it when others invade his personal space. When he is upset or angry he will storm off but will not lash out at others. His pacing has been noted to increase in speed as he waits for meals to be served. He does not like anyone checking his pockets and can get agitated if he is not approached with tact."	I 229		

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I 229	Continued From page 7 Pocketing items that do not belong to him: This behavior may serve the simple function of providing satisfaction by acquiring items that catch his fancy." Interview with the house manager (HM) on September 20, 2010 at 4:16 p.m. revealed the facility's staff had not been trained on Resident #1's BSP. At the time of the survey, the GHMRP failed to ensure the staff had been trained on Resident #1's BSP.	I 229		
I 333	3517.11 ADMISSION POLICIES PROCEDURES No later than ten (10) days after the date of admission, the GHMRP director shall ensure that implementation of the Individual Habilitation Plan is begun for each resident who is admitted with an Individual Habilitation Plan. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the implementation of the client's individual support plan (ISP) as required by this section for one of two of the residents included in the sample. (Resident #1) The finding includes: Interview with the facility's qualified mental retardation professional (QMRP) on September 20,2010 at approximately 4:14 p.m., revealed Resident #1 was admitted to the facility on September 7, 2010. According to the QMRP and review of the resident's habilitation record, the resident had transferred with a Individual Support Plan (ISP) dated May 16, 2010. In addition, his Individual ISP was being amended, however, the interdisplinary team made no changes. Further record review on the same day at approximately	I 333	Please find attached 11/5/10 training documentation on individual's ISP goals. The training started on 9/17/10 and all staff were completed by 10/21/10 according to the Schedule. Additionally all staff recieve on-going training and specific ISP goal training annually or as needed.	

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I 333	Continued From page 8 5:09 p.m. revealed the following ISP recommendations had not been implemented to date: 1. Resident #1 will go for a walk in the community four (4) times a week with verbal prompts; 2. Resident #1 will participate in a simple exercise riding a stationary bike for fifteen minutes with 50% verbal prompts on ten (10) occasions for twelve (12) consecutive months; 3. Resident #1 will learn to turn on and off his nebulizer with 50 % verbal prompts on ten (10) consecutive occasions for six (6) months; 4. Resident #1 with verbal prompts will practice writing his phone number two (2) days a week on twelve (12) consecutive months. Interview with the facility's staff on September 20, 2010 at approximately 5:00 p.m., revealed that she/he was not familiar with any of the above recommendations or goals. Continued interview with the QMRP indicated that he was waiting for the amended document being prepared by the resident's case manager. At the time of the survey, the GHMRP failed to ensure the timely implementation of Resident #1's ISP as required by this section.	I 333		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as	I 374		

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I 374	Continued From page 9 soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the guardian received timely notification of an injury of unknown origin for one of two residents included in the sample. (Resident #3) The finding includes: The facility failed to notify Resident #3's next of kin of an injury of unknown origin as evidenced below: On September 20, 2010 at approximately 9:56 a.m., interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the unusual incident reports revealed, Resident #3 was discovered on September 24, 2009 with three (3) abrasions on the left side of his face. According to the QMRP, Resident #3's next of kin was his sister. Continued interview with the QMRP revealed the group home's incident management procedures included that it was the QMRP's responsibility to contact the legal guardian or next of kin. Further interview with the QMRP revealed that he was not an employee at the time of this injury. At the time of the survey, there was no documented evidence of the resident's sister being notified of Resident #3's injury.	I 374	Please find attached our reporting requirements which include D.O.H. and family members within 24 hours. Upon research of the MCIS system there was no incident entered into the system by the day program for any of our individuals during September 2009, except for S.W. who was with another provider at that time.	11/5/10
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5,	I 379		

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I 379	Continued From page 10 each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, (HRA) for one of the three residents (Resident #3) included in the sample. The finding includes: On September 20, 2010 at approximately 9:56 a.m., interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the unusual incident reports revealed, Resident #3 was discovered by the day program on September 24, 2009 with three (3) abrasions on the left side of his face. It should be noted that the abrasions were of an unknown origin. Continued interview with the QMRP revealed the group home's incident management procedures included that it was the QMRP's responsibility to contact the legal guardian/family, Developmental Disabilities Services, and that Department of Health is only notified of "serious reportable" incidents.	I 379	See 1374.	11/5/10

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I 379	Continued From page 11 At the time of the survey, the facility failed to report this incident to the Department of Health (DOH) within 24 hours.	I 379		

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R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have background checks completed for one of seven staff of which three are Trained Medication Employees (TMEs) and (TME #3 did not have the criminal back ground check.) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on September 20, 2010, at approximately 1:30 p.m. revealed that one (1) of three (3) Trained Medication Employees (TME) assigned to the facility failed to have a criminal background check in their file. This was acknowledged by the QMRP at approximately 4:30 p.m.	R 122	11/5/10 Background checks on TME is in staff's file and available for review.	